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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

~~25~~4. RESPIRATORY CARE SERVICES: Payment will be made at lesser of usual and customary or at 70% of physician fee scale.

07/91 ~~26~~5. PERSONAL CARE SERVICES: Payment will be at the minimum wage plus Social Security (FICA). If no provider is available at minimum wage, payment will be based on a fee-for-service paid at the lower of two or three bids by individuals with experience in the community who are available to meet the demand.

10/91 ~~27~~6. CASE MANAGEMENT FOR EPSDT: Payment will be made for case management services through established fee screens related to needs of individual children. Payment will be made for case management services provided to Medicaid eligible children age birth to 21. Case management services include referring the participant to or discussing the need for routine or acute pediatric care. This includes discussion and referral to preventive medical and dental services provided to children consistent with the Academy of Pediatric guidelines. Case management may include informing clients of available services, scheduling or notifying them of their appointments and arranging transportation. Case management includes locating, coordinating and monitoring necessary and appropriate medical care identified during a health screening.

The fee screens have been established for the following groupings of EPSDT Medicaid eligible children:

- Chronically ill and physically disabled children age birth to 21 who, under special program considerations, may live in their own home or home-like environment if the cost of such services is less than institutionalization and is in the best interest of the child;
- Functionally limited children with multiple needs or a high level of vulnerability who, as shown by an assessment, require mental health case management;
- Children identified as HIV positive and at risk of institutionalization or the result of AIDS related symptoms who, as shown by an assessment, require case management and additional services of personal care, homemaker services, assistive devices and electronic home response or other equipment;

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- Physically disabled children age 0 to 21 who live in their own home who require less than shift nursing but otherwise need a level of care equivalent to SNF or ICF;
- Children age 0 to 3 at risk of developmental delay who require early intervention;
- Children age birth to 21 years with medical needs who also receive special education services;
- Infants at risk of infant mortality as a result of cocaine, genetics or medical condition; and
- Children who are Medicaid eligible who have identifiable symptoms, risks or behaviors that are interfering with the quality of life and can be helped by a treatment plan and recognized medical care and supervision.

10/91 TARGETED CASE MANAGEMENT - TARGET GROUP A

Hourly payment rates for case management services for both public and private providers are computed from the following factors:

1. hourly wages and salaries for direct care staff (QMHP, MHP and RSA) who are authorized to provide billable services;
2. hourly paid benefits for direct care staff;
3. hourly Medicaid-reimbursable community provider operating expenses other than direct care staff salaries, wages and paid benefits;
4. time spent in delivery of services; and
5. client:staff ratios.

The annual maximum units for case management services/coordination will not exceed 240 hours. Such units are billed in 15 minute increments. The annual maximum units for rehabilitative transition linkage and aftercare services shall not exceed 40 hours and such units are billed in 15 minute increments.

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10/94 TARGETED CASE MANAGEMENT - GROUP C

Reimbursement is on a monthly basis. Payment will be the lesser of charge or the maximum statewide rate developed. The maximum rate will be reviewed and the rate may be adjusted downward so that the rate is comparable to other provider fee schedule rates for similar services. The base period for establishing the rate is the previous full fiscal year using audited financial statements from the providers of service. All rates are prospective; there will no cost settlement at the end of the year.

The initial rate was established using a cost survey of early intervention programs selected randomly throughout the State without regard for their funding source. Programs were asked to detail their personnel and nonpersonnel costs for State fiscal year 1994. The cost survey is supported by a time study to capture all of the other activity involved in conducting a face-to-face encounter with an eligible child. Staff completed the activity worksheets in fifteen minute increments for at least 10 days and up to one month.

The rate methodology to establish the maximum statewide rate for targeted case management for early intervention services is:

1. the sum of annualized reasonable costs, taking into account only the percentage of costs associated with the delivery of targeted case management, i.e., salary with benefits, rent and facility costs, travel, training, supplies and equipment, telephone and administration;

2. divided by the average daily case load as determined through the random cost surveys and as approved by the Department; and

3. divided by 12 for monthly billing amount.

The uniform rate may be adjusted annually, either upward or downward, based on the Consumer Price Index inflation factor.

The methodology used is within the upper limits of payment for comparable Medicare services.

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07/91 ~~28.~~ 27.CHRISTIAN SCIENCE NURSE: Payment will be at the lower of their charge or the prevailing community rate not to exceed the maximum fee screen established for a registered nurse.

01/92 ~~29.~~ 28.SCREENING SERVICES:

Mammograms

Payment shall be made at the same rate as the Department-established rate for a bilateral x-ray.

07/95 ~~30.~~ 29.CERTIFIED FAMILY OR PEDIATRIC NURSE PRACTITIONER:

A certified family or pediatric nurse practitioner may bill the Department only for services which have been personally provided by the individual nurse practitioner. Payment shall be made at 70 percent of the usual and customary rate or the maximum rate established by the Department for physician services, whichever is less.

07/98 30. Supplemental Incentives for Training and Education: Payment will be made for the training and education of health professionals through the Supplemental Incentives for Training and Education (SITE) program.

a. To qualify for payment, an enrolled clinic must:

i. be located in a medically underserved area of the state;

ii. provide a minimum of 4000 encounters per year to Medicaid clients; and

iii. be awarded payment from the Illinois Department of Public Health (IDPH) for the training and education of health professionals that are likely to ultimately established professional practices in the area of the state in which they are being trained, be located in a medically underserved area of the state.

b. SITE payments shall be made to cover the direct costs associated with providing Medicaid services. Payment rates shall equal the product of:

i. The total SITE payments made by the IDPH to the qualified clinic in a 12 month period, multiplied by;

ii The percent of annual services provided by the SITE clinic to persons eligible for Medical Assistance.

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HEALTH MAINTENANCE ORGANIZATION (HMO) RATE SETTING

The overall goal of the Department's current rate setting methodology is to develop the best estimate of probable costs for providing all covered medical services, including obstetrical and pediatric care, to a nonenrolled actuarially equivalent population of AFDC-MAG recipients residing in the service area during the contract year.

The objective is to provide contracted monthly premium amounts on a per enrollee basis by age and sex. The amounts calculated through the rate setting process represent the maximum allowable capitation premiums which the State may pay.

The Department's calculation of the maximum allowable reimbursement rates for HMO providers is guided by Federal Regulation 42 CFR 447.361 which states:

> Under a risk contract, Medicaid payments to the contractor, for a defined scope of services to be furnished to a defined number of recipients, may not exceed the cost to the agency of providing those same services on a fee-for-service basis, to an actuarially equivalent nonenrolled population group.

Overview of the Current Rate Setting Methodology

A maximum beyond which an HMO's rate may not exceed is based on the fee-for-service (FFS) experience of an equivalent population. Specific geographical estimates are developed based on actual paid claims for a date of service (DOS) period. In order to account for all claims related to the DOS period, including the obstetric, pediatric and other related claims, historical data are used and inflated forward to the midpoint of the period for which the fee-for-service equivalents are being calculated. The total dollars expended for the DOS period are then aggregated by age and sex of the fee-for-service population. The traditional age cohorts utilized by the Department are 0-2, 3-13, 14-20, 21-44, and 45+. The total dollars expended for the DOS period is then divided by the total number of eligible recipient months for the DOS period resulting in an "experience period" FFS equivalent capitation, based on the fee levels paid by the Department to obstetric, pediatric and other providers, and the anticipated level of service utilization.

Adjustment to these costs are made for service plan differences (e.g., removal of dental claim payments, Department of Mental Health and Developmental Disabilities, long term care and, conditionally, optometric expenditures), TPL recoveries and nonclaims costs (i.e., C-13 payments) accruing outside of MMIS. The Department will continue to pay enhanced fees for certain procedures. These fee changes are being factored into a revised HMO rate base to allow participating HMOs to provide similar fee enhancements to their practitioners.

A medical cost change factor is then applied to project the base year capitation to the "contract period." The Department will ensure that the capitdation rate is actuarially sound.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Item _____. Payment of Title XVIII Part A and Part B Deductible/Coinsurance

Except for a nominal recipient co-payment, if applicable, the Medicaid agency uses the following method:

	Medicare-Medicaid Individual	Medicare-Medicaid/QMB Individual	Medicare-QMB Individual
Part A Deductible	X limited to State plan rates*	X limited to State plan rates*	X limited to State plan rates*
	___ full amount	___ full amount	___ full amount
Part A Coinsurance	___ limited to State plan rates*	___ limited to State plan rates*	___ limited to State plan rates*
	X full amount	X full amount	X full amount
Part B Deductible	X limited to State plan rates*	X limited to State plan rates*	X limited to State plan rates*
	___ full amount	___ full amount	___ full amount
Part B Coinsurance	X limited to State plan rates*	X limited to State plan rates*	X limited to State plan rates*
	___ full amount	___ full amount	___ full amount

*For those title XVIII services not otherwise covered by the title XIX State plan, the Medicaid agency has established reimbursement methodologies that are described in Attachment 4.19-B, Item(s) _____. Non-Medicaid covered services will be paid at the full Medicare deductible & coinsurance amounts.